

EARLY EGO INTEGRATION AND OBJECT RELATIONS

Otto F. Kernberg

*The Menninger Foundation
Topeka, Kansas 66601*

INTERPERSONAL INTERACTION AND INTRAPSYCHIC STRUCTURES

My main thesis is that the structures determined by *internalized* object relations constitute a crucial determinant of ego integration and an abnormal development of internalized object relations determines varying types of psychopathology.

Abundant evidence has been accumulated in recent years indicating that the psychological development of the child is strongly under the influence of the early mother-child relationship. Bowlby's studies⁶ relating maternal deprivation with later development of incapacity in the child to establish normal object relations and with severe forms of psychopathology have been supported by clinical evidence and more recent research.^{1,16} Under the influence of ethological observations regarding early attachment to the mother in primates, there has been a growing interest in studying attachment in human infants.^{2,45} Bowlby⁵ has criticized the traditional psychoanalytic theory in which the need for food and the gratification of oral-libidinal strivings develop into the libidinal investment of mother. By contrast with this "secondary drive" model of attachment to mother, Bowlby⁷ suggests that investment in mother represents a "primary drive" expressed by inborn behavior patterns (sucking, crying, clinging, smiling, and following) that act as releasing mechanisms of mothering behavior and bring about reciprocal reinforcement of mutual mother-child investment.

It seems to me that the controversy between traditional psychoanalytic instinctual theory on the one hand (according to which object investment is secondary to the expression of libidinal or aggressive instinctual needs), and psychoanalytic object relations theory on the other (particularly Fairbairn's¹² and Bowlby's⁷ stress on the primary nature of the infant's attachment to mother), may be resolved in the light of an additional dimension of early development; namely, the differentiation of "rewarding" (libidinally gratifying) and "punishing" (painful, frustrating, frightening experiences triggering aggression) experiences in the early mother-child interaction into early intrapsychic structures culminating in a set of structures representing "internal object relations." This conceptualization implies that early maternal deprivation determines abnormal personality development through the intermediate variable represented by faulty internalized object relations.

In more general terms, instincts are expressed *first* as inborn behavior patterns that release in an "average expectable environment"²² mothering functions and interpersonal interactions; and *later* are expressed as internalized object relations that, in turn, are a crucial organizer of all other psychic structures. This conceptualization represents an attempt to integrate psychoanalytic instinct and object relations theories.²⁸ For partly historical reasons, they have often been made to sound antithetical or in competition. Because of difficulties in studying intrapsychic developments during the preverbal stage, direct research on earliest internalized object relations is not yet available. However, Piaget's studies^{13,41} on early development of cognitive structures represent a promising approach to this problem. His approach has recently been applied to the study of affective development and object relations.⁹

Clinical evidence from studies of children with autistic and symbiotic psychoses³² and from psychoanalytic exploration of adolescents and adults with severe character pathology and borderline conditions^{19,25} indicates that the type and severity of psychologi-

cal illness is, indeed, largely the expression of pathological structuring of internalized object relationships. The psychoanalytic situation permits the activation of past internalized object relations in the transference, and constitutes an excellent research tool for the study of these intrapsychic structures. The integration of studies of the transference in the psychoanalytic situation with dynamic studies of early infant-mother relationship of the same subjects may constitute a valuable research design in this area.

Other contributions to the study of normal and pathological internalized object relationships have come from recent research on the etiology of schizophrenia. Of particular interest are findings in schizophrenic patients regarding perceptual imbalance,^{40,49,52} in "high risk" individuals regarding abnormal reactivity of the autonomic nervous system,^{33,34,36} studies of pathological family interactions and structure,^{3,31,35} and especially psychoanalytic exploration of the relationships between pathological interpersonal functioning and intrapsychic structuring of object relations,^{8,43,48} and regarding the relationships between intrapsychic and interpersonal object relations on the one hand, and pathological cognitive functioning on the other.^{4,17}

In what follows, I will outline a model of normal and pathological development of internalized object relations and, in the process, define units of internalized object relations, stages in their development, and types of psychopathology related to these stages. I will also integrate findings from behavioral studies of infancy, from research on the etiology of schizophrenia, and from psychoanalytic exploration of borderline and psychotic patients into a common frame of reference. I will emphasize particularly the integrative functions of internalized object relations regarding 1) differentiation between self and nonself, 2) the establishment of ego identity, 3) the development of the superego, 4) the availability of assets usually designated as "ego strength," and 5) the capacity to establish consistent and deep relationships with other human beings.

FOUR STAGES OF DEVELOPMENT OF INTERNALIZED OBJECT RELATIONS

The internalization of object relations may be divided into four basic developmental sequences.

Stage 1

Stage 1 is the earliest stage of development and precedes the establishment of the primary, undifferentiated self-object constellation built up under the influence of pleasurable, gratifying experiences of the infant in interactions with his mother.²³ There exists evidence that the infant may be capable of "recognitory" evocation of the mothering one as early as at 10 weeks of age,¹⁵ and that the establishment of the primary, undifferentiated self-object representation probably takes place somewhere between the fourth and the twelfth week.³²

Stage 2

The second stage of development of intrapsychic object relationships consists of the establishment and consolidation of an undifferentiated self-object image or representation^{23*} of a "rewarding (or "libidinally gratifying") type under the organizing influence of gratifying experiences of the child-mother unit. Inborn behavior patterns of the infant (particularly crying) signal to the mothering one states of psychophysiological imbalance and stress. Need-satisfying behavior of the mother activates multiple perceptions in the infant involving touch, smell, and particularly in-traceptive and proprioceptive sensations included in the nonspecific, "coenesthetic" con-

*I will use the terms *image* and *representation* as equivalents in this presentation.

stellation of stimulus modalities.^{15,50} Hypothalamic and other "reward" centers³⁷ probably contribute to integrate these basic constellations of primitive perceptions through an affective coloring of an overall pleasurable, rewarding "all good" type. Thus, a primary intrapsychic structure is built up, with memory traces fixating the primitive coenesthetic constellation and its gratifying "all good" affective quality; this constitutes the primary, undifferentiated, self-object representation. Simultaneously, a separate primitive intrapsychic structure representing an undifferentiated "all bad" self-object representation is built up under the influence of painful and frustrating psychophysiological states. The rapid rate of increase of physiological disequilibrium, and the diffuse, pervasive nature of painful early experiences contribute to building up such an "all bad" self-object image separate from and in contrast to the "all good" self-object image referred to earlier. Again, hypothalamic "punishment" centers infuse this early, coenesthetic constellation of stimulus modalities with a painful, frightening, aggressive "all bad" affective tone.³⁶

In this way, two sets of opposite primitive constellations of self-object-affect dispositions are built up and fixated by memory traces as polar opposite intrapsychic structures. The "good" self-object representation determines the "recognitory" evocation of the mothering one;¹⁴ that is, total activation of the "good" self-object representation when perceptive stimuli related to this constellation emerge in the experiential field (for example, when light flashes on in the hungry baby's room), and as a consequence of this activation, attachment behavior develops. In Erikson's terms,¹⁰ this is the structure underlying "basic trust" (a structure predating the differentiation of self from object representation and the recognition of mother as an independent object). At this stage, there is as yet no separation between self and nonself, and therefore there are only rudimentary ego boundaries.

Stage 3

The third stage of development is reached when the self-image and the object-image have been differentiated within the core "good" self-object representation. The differentiation of self from object-image within the core "bad" self-object representation occurs later and is complicated by the development of early types of projection; that is, intrapsychic mechanisms that attempt to externalize the "bad" self-object constellation and probably determine the intensity of "stranger anxiety" between six and ten months of age.^{24,51} The differentiation of the self-image from the object-image occurs normally under the influence of perceptual and cognitive growth, but may be retarded or even completely interfered with under circumstances of excessive frustration or serious disturbance in the mother-infant relationship from the second half of the first year on. Under such circumstances, a defensive refusion of the self- and object-image may occur in order to reactivate the earlier intrapsychic state of complete satisfaction. This is represented by the fused "all good" self-object image with concomitant loss of differentiation between self and nonself, and the consequent blurring of ego boundaries and reality testing.²³ The differentiation of self from nonself is crucially influenced by the differentiation of self and object-images. The differentiation of self from others, in the interpersonal realm, is facilitated by the child's active exploration of the nonhuman environment and his growing experience in controlling sensory-motor input coming from separate yet "controllable" inanimate objects.^{47,53} Insofar as the "good" self-images and the "bad" self-images are separate from each other, there exists as yet no integrated concept of the self; however, ego boundaries do stabilize, because self-images are separate from object-images now, and, therefore, self becomes differentiated from nonself.²³ Also, insofar as "good" and "bad" object-images are separate, there is as yet no integrated conception of other human beings (and this constitutes the "part-object relationships"³⁰ of British psychoanalysts). "Object constancy"¹⁴ in the psychoanalytic sense is not yet available, nor, of course, is cognitive "object permanency" in Piaget's sense.⁴¹

Stage 4

The fourth stage of development of internalized object relations comes about somewhere between the end of the first year of life and the second part of the second year and continues evolving through various substages throughout childhood. Cognitive (visual) object permanency is reached at about 18 months,⁴¹ and affective (or, rather, libidinal) "object constancy" is probably reached somewhat earlier.¹⁴ However, because this stage is much more complex and variable than the earlier stages mentioned, the time span involved is still a matter of disagreement on the part of workers in this field.¹⁵

During stage 4, "good" and "bad" self-images coalesce into an integrated self-concept. In other words, self-images under the impact of polar opposite emotional and interpersonal experiences establish continuity; affects become integrated, toned down, and differentiated; and the child's self-concept and his actual presentation or behavior in the social field become closer. (The more integrated the self-concept, the more the individual's self-perception corresponds to his actual interpersonal impact in each concrete interaction.) At the same time, "good" and "bad" object-images also coalesce, so that good and bad images of mother become integrated into a total conception of mother that comes close to the actual reality of mother in the interpersonal field of the child. At the same time, the coalescence of good and bad object-images fosters better discrimination among the object-images stemming from interpersonal relationships with all other significant people in the child's social field. To put it differently, object-images coalesce into more realistic representations of significant others seen as integrated individuals. An integrated self-concept, "surrounded," as it were, by an integrated conception of others, with ongoing modification of self-concept and concept of others in the process of interpersonal relationships, constitutes "ego identity" in the broadest sense.^{11,24}

Cognitive developments certainly influence this integration of self- and object-images. Even under certain psychopathological conditions when the mechanism of "splitting" (that is, active dissociation of contradictory ego states²⁴) develops excessively, such cognitive developments still permit other people to be recognized realistically as independent objects with permanent characteristics in time and space. However, lack of integration of internalized object relations of a "good" and "bad" kind leads to an inability to understand in depth one's own self and the personality of others. This leads to lack of realistic self-awareness and of empathy with others. Borderline patients characteristically fail to achieve the developmental tasks of stage 4 and must guide their actions by ongoing, direct observation of their behavioral interactions with others. Such patients cannot rely on the "intuitive" indicators of interpersonal reality derived from normal development of internalized object relations.²⁸

To this point, the essential units of internalized object relations described above have consisted of a self-image, an object-image, and a certain ("good" or "bad") affect disposition linking them. As a consequence of the integration of the self-concept, however, a new structure develops within the realm of internalized object relations, namely, "ideal self-images" coalescing into an "ideal self." This is a consequence of the child's realistic awareness that earlier fantastic, idealized images of the "all good" self do not correspond to reality, and that a certain discrepancy exists between what he himself is like and what he wants to be. The same development takes place in the integration of object representations; realistic, integrated object representations are now contrasted with ideal object-images that attempt to re-create in fantasy the now lost "all good" object representation. Complex integration of the ideal self-concept with ideal object-images determines an intrapsychic, personalized structure that demands achievement of an ideal state of the self and an ideal type of relationship with the ideal object. This overall structure, together with the internalization of the prohibiting aspects of the parental figures, becomes part of the superego. However, the development

of the superego is complicated by the child's misperception of parental demands and prohibitions due to the projection of earlier "all bad" self and object-images onto the parental figures, which first distorts the early perceptions of the parents, and later brings about internalizations of fantastic sadistic demands and prohibitions into the superego.²³

In short, stage 4 presents much further differentiation as well as integration of internalized object relations and includes new intrapsychic structures. Foremost among these is the later development of a more differentiated superego that integrates the ego ideal, the sadistically distorted images of parental figures when demanding or forbidding, and the realistic perceptions of parental commands. Actually, superego integration has several "substages," and probably extends from the second or third year of life on to the fifth to seventh year, with further reorganization occurring during adolescence.

The normal chronological ranges of these four stages of development of internalized object relations are uncertain, given the difficulties of exploring the development of intrapsychic structures in the first few years of life. These difficulties become even more complicated when pathological distortions alter the normal sequences and determine pathological structures that may remain fixed for the entire life of the individual. In what follows, I will briefly review the preconditions, characteristics, and consequences of failure of normal development of these four stages of internalized object relations.

PATHOLOGY OF INTERNALIZED OBJECT RELATIONS

At Stage 1

A pathological arrest or fixation of development at stage 1 would render impossible the building up of the primary "all good" self-object image, and, therefore, of the ego core determining basic trust and all other derived intrapsychic and interpersonal object relations. This lack of development of the primary undifferentiated self-object image and the consequent incapacity to establish a normal "symbiotic" relationship with mother have been hypothesized on the basis of intensive study of autistic children.³² Autistic psychoses and some very early and malignant types of "affectionless characters"⁶ that lead to later development of antisocial personality structures appear to stem from pathology at stage 1 of development.

Normality of early development of perception and perceptive integration are indispensable preconditions for establishing the normal, all-good self-object image, so that the normal "all good" coenesthetic constellation can be built up in terms of early memory traces. In general, the child needs to be able to differentiate "good" (rewarding) from "bad" (punishing) stimuli. Insufficient stimulation and gratification of the infant's psychophysiological needs, particularly of the mothering responses normally elicited by early attachment behavior patterns, appear to represent one origin of failure of the building up of the "good" ego core. It is significant that congenitally blind children have a higher incidence of autistic psychosis than normal children,¹⁵ and that a high proportion of autistic children present "soft" organic signs.²⁰

Recent research on schizophrenia has highlighted two general areas of probable etiologic significance in the failure to build up the basic, "all good" self-object representations: 1) abnormal perceptive thresholds and perceptive organization, leading to information input overload and difficulty in maintaining perceptive sets;^{40,49,52} and 2) disequilibrium in autonomic reactivity, particularly high reactivity to stress, increased generalization of stimuli, and slow extinction of the conditioned response.^{33,34,46} Although these are still tentative findings, they do strengthen the hypothesis that faulty perceptual input may interfere with the building up of the coenesthetic constellation of stimulus modalities leading to the good self-object core, and that excessive generalization of anxiety derived from excessive arousal may upset the normal, delicate balance of activation

of hypothalamic "reward" and "punishment" centers under the influence of changing physiological imbalances, thus interfering with the discrimination of "good" and "bad" psychophysiological and interpersonal states and with the building up of a sufficiently strong "all good" self-object constellation. It may also be that these perceptive or affective alterations directly interfere with normal attachment patterns and express themselves in faulty input into the normal infant-mother interaction, which, in turn, gives rise to deficient mothering and insufficient stimulation of normal coenesthetic experience.^{15,42} Direct maternal deprivation or pathological feedback from mother to the infant's attachment behavior may be another source of insufficient buildup of the basic ego core.

In the context of this presentation, it is of interest that although children with severe environmental and maternal deprivation (but without overt psychosis) present a strikingly faulty emotional, cognitive, and social development, sufficient development of self and object-differentiation occurs to permit a superficial adaptation to reality. Indeed, sometimes there develops a highly skilled manipulation of interpersonal relationships without any capacity for empathy, love, guilt, or pity. In other words, cognitive maturation and development may compensate for the lack of development of internalized object relations to the extent of bringing about differentiation of ego boundaries and reality testing in a restricted sense, but does not compensate for the crippling incapacity to establish interpersonal and intrapsychic object relations.

From a clinical viewpoint, it needs to be stressed that pathologic developments at later stages, particularly at stage 3 (which is intimately linked with the development of borderline personality organization), may bring about, in certain cases, a serious deterioration of interpersonal and intrapsychic object relations. This deterioration derives from more advanced, complex intrapsychic mechanisms that tend to devalue and destroy internalized object representations and to develop a pathologically inflated, idealized self-concept in replacement of normal ego identity. This is the case of patients with narcissistic personality structures²⁶ who are highly self-centered, manipulative, and ingratiating, and yet aloof and basically not invested in other people. By contrast with affectionless characters and derived antisocial personality structures reflecting absence of development of internalized object-relations, psychoanalytic exploration of narcissistic personalities reveals very active, pathological primitive internalized object relations (which have to be worked through in the transference situation before a basic personality change can occur). Clinically, it remains an open question as to what extent antisocial personality structures represent a failure stemming from stage 1 or from later developmental stages, to what extent they present primary lack of development of internalized object relations, or to what extent they present pathological, regressive deterioration of internalized object relations such as narcissistic personalities do.

At Stage 2

Pathological fixation or regression to the second stage of development of internalized object relations is characterized by the lack of differentiation between self and object-images and a consequent failure in the differentiation of ego boundaries and, therefore, in the differentiation of self from nonself and in reality testing. From the viewpoint of internalization of object relations, severe frustration and the consequent predominance of "all bad," aggressively "loaded," fused self-object images determine a defensive refusal of primitive "all good" self- and object-images as a protection against such excessive frustration and rage. This defensive refusal of the "all good" libidinally invested self-object image is the prototype of what constitutes a "psychotic identification,"²³ if prolonged beyond the early infantile stages of development.

Normally, the primary "all good" self-object image is the depository of primitive "positive" affect dispositions, and, in terms of psychoanalytic instinct theory, the depository of libidinally invested object-relations. The "all bad" self-object image is the

depository of all "negative" primary affect disposition, that is, of aggression both in clinical terms and in terms of psychoanalytic instinct theory. From a clinical viewpoint, overriding pathological aggression characterizes interpersonal as well as intrapsychic object relations of the psychotic patient. This is also true for borderline personality organization, but here the level of internalized object relations and the deployment of defensive mechanisms to deal with this aggression are different from the psychoses.

Blurring of the limits between self-images and object-images and the subsequent loss of ego boundaries determine loss of reality testing, a basic symptom separating the psychoses from nonpsychotic conditions.¹⁸ Under these circumstances, not only is the patient incapable of determining the external or internal origin of his perceptions, feelings, thoughts, and behavior, but he is also threatened by the danger of complete engulfment or ego dissolution in close interpersonal interactions. A patient's excessive hatred threatens to flood and eliminate whatever island of love exists in his intrapsychic constellation of object relations and in his interpersonal experience, and also distorts the threatening fusion experience in terms of intrusive, overwhelming fears of a massive, total, primitive annihilation. Defensive flight into a mystical, ecstatic, primitive idealized self-object fusion, the only escape in fantasy against these threats, may be seen both in the transference developments of schizophrenic patients undergoing psychoanalytic psychotherapy and in the desperate clinging of children with "symbiotic psychosis".^{32,48} Symbiotic psychosis of childhood, most types of adult schizophrenia, and some severe schizoid states are characteristic syndromes related to arrest of development at stage 2. Most schizoid personalities represent typical borderline personality organization, that is, failure at stage 3; some, however, in intensive psychotherapy, tend to regress to a state of self-object fusion (indicating fixation at stage 2 pathology) that is different from typical transference developments in other borderline conditions.

Regarding the etiology of pathological fixation at stage 2 of development, I have mentioned earlier research indicating that schizophrenic patients may present lowered thresholds to perceptual input leading to information input overload and excessive arousal, and/or lowering of anxiety thresholds or excessive arousal leading to diffuse, massive affective reactions, and secondary cognitive disorganization. A biological disequilibrium in autonomic reactivity may underlie both types of lowered thresholds (perceptual and affective); lowered thresholds, in turn, may determine excessive reactivity, protective withdrawal, and disorganization under the impact of affect-laden interactions. All these defects may interfere with the building up of the "all good" interpersonal experiences and their corresponding intrapsychic "all good" self-object image, and bring about a generalization of "all bad" interpersonal experiences, as well as triggering off excessive, repetitive aggressive reactions. In turn, excessive stress in the interpersonal field itself (such as a pathological family structure so typically seen in schizophrenic patients^{3,31,35}) may directly bring about early maternal deprivation and lack of harmonious development of the infant-mother relationship, and thus create a pathological predominance of aggressively determined "all bad" self-object images. This conceptualization allows for a complementary series of hereditary, biochemical, and psychosocial etiological factors in schizophrenia.

In any case, defensive escape into refusion of an "all good" self-object image will cause lack of differentiation of ego boundaries first, and of ego integration and development later. There are additional primitive defensive operations triggered off under these circumstances, such as excessive use of primitive projective mechanisms in order to "expel" the "all bad" internalized object relations, leading to paranoid distortions of the significant others in the interpersonal field and to efforts at omnipotent control to deal with them.^{30,43} Another primitive defense excessively activated is excessive splitting, namely, pathological dissociation of polar opposite ego states in order to prevent an all-pervasive anxiety and fear of destruction; defensive disorganization of cognitive processes, contributing

further to the severe disorganization of schizophrenic patients has also been described.⁴

Pathological utilization of primitive projective mechanisms also interferes with the normal differentiation of the human from the nonhuman environment. In general, while stage 1 implied the development of differentiation of significant from nonsignificant stimuli and of "good" from "bad" stimuli, stage 2 centers around further differentiation of "good" from "bad," with the added tasks of differentiating self from nonself, and human from nonhuman. The playful control of nonhuman objects may have important functions in the self-nonself differentiation;^{47,53} and the projection of primitive, frightening, "all bad" self-object images onto the immediate inanimate environment determining primitive phobic fears and inhibition of play may contribute to the lack of differentiation between self and nonself in schizophrenic patients. This contrasts with the normal growth potential of effective handling of the "neutral" world of inanimate objects in early exploration and play.

In contrast to patients with autistic syndromes and antisocial personality structure, acute types of adult schizophrenia and symbiotic childhood psychosis are characterized by very intensive, although primitive and "psychotic," transference reactions and capacities for interpersonal involvement. Clinically, for both acute and chronic schizophrenic patients, the prognosis is strongly influenced by the patient's remaining capacity to establish object relations in the "here and now."¹⁷

At Stage 3

From the sixth to eighth month on, the baby not only recognizes the mother but begins to search actively for her. At this point, the infant probably still presents "recognitory" evocation of mother under the influence of need activation; however, it may be that within the area of interpersonal relations (by contrast with the relationship to inanimate objects), the capacity for "anticipatory" recognition and the related establishment of object permanency becomes gradually established well ahead of the time (approximately 18 months) when object permanency becomes established in the nonhuman field.¹⁴ In any case, the infant is probably aware that mother and self are separate beings much before he is able to conceive of mother as an independent, permanent object in time and space. It is at this stage, from six months to a year and a half, that primitive idealization of the mothering one as the "all good" object, in defense against the contamination of this image by the "all bad" object image under the influence of frustration, becomes predominant. The simultaneous differentiation of the mothering one and development of "stranger anxiety" may be caused by projecting onto the unknown person the bad self- and object-image that is by now actively dissociated from the good self- and object-image. This active dissociation of polar opposite self- and object-images constitutes the mechanism of splitting, normally active at stage 3, but which, when exaggerated and persistent, may interfere with integration of the self and of object representations. Normal splitting may contribute to keeping the good relationship with mother in the face of frustration and protect the self against otherwise confusing and overwhelming contamination of love and hatred.^{12,30} Pathological splitting of the perception of other people into "all good" ideal ones and "all bad" persecutory ones is a central defensive mechanism of patients with borderline personality organization who present a pathological fixation or regression to stage 3 of development of internalized object relations.²⁵

The various phases of the syndrome of maternal deprivation in infants^{9,51} may reflect the vicissitudes of internalized object relations as affected by maternal deprivation. The stage of initial search behavior and rage after abandonment by mother may represent the activation of the "all bad" self- and object-image, the absence of the "good mother" being equivalent to the activation of the "bad mother." The later phase of resignation, indifference, and final disappearance of the capacity for attachment may reflect the

eventual deterioration of the good self-object image and the consequent weakening of attachment behavior (now intimately dependent on internalized object relations). The reaction of the infant toward the mothering one after a period of deprivation may illustrate how the image of the mother has become contaminated with the "all bad" self- and object-image. After some initial distance, intense angry feelings are expressed to the mother, simultaneously with the reactivation of clinging and general attachment. It is as if love and hatred were still available but so contaminated that the infant can only gradually reestablish the good self- and object-image. The mother's tolerance of his aggression during this stage may have crucial consequences for the infant's future intrapsychic and interpersonal object relationships; the mother's tolerance of anger and her continuing provision of love may crucially strengthen the infant's conviction in the strength of the good self and the good object, and decrease his fear over his own aggressive tendencies. Early projection may complicate the picture in this phase of development, the infant attributing to the mothering one his own rage because of his frustration, with consequent setting up of a vicious circle in which the mother's behavior is misinterpreted in terms of "paranoid" distortions of her, and with subsequent reinforcement of the bad self- and object-image.

In general, normal and pathological development of attachment during this stage and their respective consequences for personality development depend heavily on the vicissitudes of the internalized counterparts of interpersonal interaction.

Failure at stage 3 of development of internalized object relations determines borderline personality organization.²⁵ This includes several types of severe character pathology, such as many "impulse neuroses" and addictions, many narcissistic personalities, most infantile personalities, and most antisocial personality structures (except those deriving directly from autistic conditions and the affectionless character syndrome of early childhood). The so-called "chaotic," "as if," "inadequate," and other severe types of personality disorders also present typically borderline personality organization. I have examined this syndrome extensively in other papers, and will review here only briefly the implication of pathological internalized object relations of these patients for their lack of ego integration and pathological ego and superego functioning.

In the case of borderline personality organization, differentiation of self-images from object-images has occurred to a degree sufficient to permit the establishment of integrated ego boundaries and a concomitant differentiation between self and others. However, the characteristic task that differentiates stage 3 from stage 4 (namely, the integration of self- and object-images of the "good" type with their corresponding self- and object-images of the "bad" type normally leading to an integrated self-concept and an integrated concept of objects) fails, to a great extent, in borderline patients, mainly because of the pathological predominance of primitive aggression. The problem at this point is that the intensity of aggressively determined self- and object-images and of defensively idealized all good self- and object-images makes integration impossible. Bringing together extremely loving and hateful images of the self and of significant others would trigger unbearable anxiety and guilt. The result is active defensive separation of such contradictory self- and object-images; in other words, primitive dissociation or "splitting" becomes a major defensive operation.

Lack of integration of self- and object-representations is at first a normal characteristic of early development, but later such lack of integration is used actively, and splitting actually constitutes the predominant defensive operation of these patients, reinforced by primitive idealization, primitive types of projection (projective identification), and other related mechanisms. These are the same defensive operations characteristic of psychotic patients. The main thrust of this defensive constellation, however, in the case of borderline conditions is to separate hatred and love completely from each other, while the main thrust of this defensive constellation in the case of the psychoses is

as a protection against fear of engulfment and annihilation.²⁸ Environmental factors, particularly severe, chronic frustrations in early childhood, appear as the predominant etiological factor.

Clinically, borderline patients present preservation of reality testing, but serious difficulties in their interpersonal relationships and in their subjective experience of reality. They present contradictory character traits, chaotic coexistence of defenses against and direct expression of primitive impulses, and lack of empathy for other people and incapacity to understand them in depth. They present the syndrome of identity diffusion.¹¹ They show such manifestations of ego weakness as lack of impulse control, lack of anxiety tolerance, and lack of sublimatory capacity. They also present a characteristic pathological condensation of pregenital and genital aims under the overriding influence of pregenital aggressive needs.

All these characteristics stem largely from their pathology of internalized object relations. The lack of integration of self-images determines the syndrome of identity diffusion and a chronic overdependence on others in an effort to achieve some continuity in action, thought, and feeling in relating to them. Contradictory self- and object-images contribute to contradictory character traits and to the lack of understanding, empathy, and capacity for relationships in depth with others. Superego integration is defective because normal superego development presupposes an integration of the self-concept, an integration of object representations, the normal development of ideal self and ideal object constellations, and the capacity for realistic perception of demanding and prohibitive aspects of the parental figures. All of these developments being defective, superego integration is defective also, and this further interferes with overall ego integration.

The manifestations of ego weakness may well be due to the lack of integration of "good" and "bad" self and object representations. The integration of loving and hateful feelings in the context of internalized relationships with others seems to be a major precondition for what in psychoanalytic instinct theory is called "neutralization" of instinctual energy.²¹ Such lack of neutralization, in turn, seems to deprive the ego of an important source of sublimatory potential and of the "conflict-free" ego sphere. The very lack of emotional differentiation derived from the lack of integration of love and hatred may, in itself, bring about a persistence of primitivization of emotions, with secondary lack of impulse control.

Of particular interest in borderline patients are severe self-destructive patterns, reflecting the lack of normal integration of aggressively determined, internalized object relations. I have suggested elsewhere,²⁹ from the viewpoint of psychoanalytic object relations theory, that channeling of aggressive instinct into the matrix of the psychic apparatus from which the ego and the self develop serves a biologically protective function; prolonged infantile dependency determines the need to channel aggression predominantly into internalized self and object representations rather than to discharge it externally onto the mothering figure. This inward direction of aggression is normally elaborated into stable internalized object relations that guarantee successful neutralization of aggression. This mechanism fails in patients with borderline personality organization, and this failure may be considered an important reason for their serious self-destructiveness. Also, the peculiar contamination of sexual with aggressive drive derivatives in these cases seems to reflect the failure of a normal progressive sequence; namely, the growing out of pregenital conflicts by means of establishing the sexualized childhood relationships characteristic of the oedipal period. In borderline patients, premature sexualization and oedipalization of the relationships with parental figures and siblings leads only to aggressive "contamination" of these relationships, and of the later sexual life of these patients in general.

Although we cannot go into a detailed analysis of pathological superego functioning of borderline patients, one general consequence of their lack of superego integration

needs to be mentioned; namely, the lack of advanced superego functions such as the abstraction, depersonification, and individualization of the superego that would normally lead to general value systems and internalized guidance systems that are so crucial in normal, autonomous personality functioning. The overdependency of borderline patients on external sources of reassurance, praise, and punishment derives, in good part, from their faulty superego development.

At Stage 4

Pathological conditions at stage 4 of development of internalized object relationships are represented by the neuroses and the "higher levels" of organization of character pathology,²⁷ particularly hysterical characters, obsessive-compulsive characters, and depressive-masochistic characters. The unconscious pathogenic intrapsychic conflicts of these patients and the structural preconditions for these psychopathological conditions stem from conflicts between the ego on the one hand, and a relatively well-integrated, although excessively severe and punitive superego on the other.

These patients have a well-integrated ego, and ego identity and its related components, namely, a stable self-concept and a stable "representational world"⁴⁴ (the sum of integrated, internalized object representations), are well established. The defensive mechanisms in these patients center around repression rather than around splitting, as in the earlier conditions mentioned before.^{24,27} The patient's ego at this level may be somewhat limited and constricted by its excessive use of neurotic defensive mechanisms, but the patient's overall social adaptation is not seriously impaired. He does not have the symptoms of ego weakness mentioned above. He has fairly deep, stable object relations and is capable of experiencing a wide variety of differentiated affective responses. Typically, infantile genital and oedipal conflicts are clearly predominant over pregenital conflicts. In these patients, and in normality, there is no particular pathology of internalized object relations beyond that of highly individualized neurotic transference dispositions.

Normality, by contrast with pathological developments at stage 4, represents a final progression toward a well-integrated and less severe and punitive superego, a realistically discriminating set of superego demands, ego ideals, and ego goals, all of which permit an overall harmony in dealing with the external world as well as with instinctual needs. A firm repressive barrier against a residue of unacceptable, infantile instinctual needs is complemented by a large sector of a conflict-free, flexibly functioning ego and the capacity to suppress some realistically ungratifiable needs without excessive stress.

INTERNALIZED OBJECT RELATIONS, INSTINCT, AND THE SOCIAL SYSTEM

The major emphasis of this paper has been on internalized object relations, in contrast to the focus on actual interpersonal relations and their influence on personality formation. However, there is, of course, an intimate, reciprocal relationship between actual interpersonal relations and their respective intrapsychic structures. Psychoanalytic object relations theory has come a long way, it seems to me, toward bridging the gap between the sociocultural theories of personality on the one hand, and the constitutionally focused, instinct-centered theories within psychoanalysis and other related personality theories on the other. Modern ethological findings and concepts highlight the importance of early attachment in the development of normal personality, and, as mentioned in the initial part of this presentation, longitudinal observation on human infants and children as well as clinical experience are providing corresponding evidence regarding the human personality. I have stressed the importance of the intrapsychic, subjective phenomena accompanying and derived from attachment, and have suggested that instinct is expressed

in attachment patterns first, and then anchored in internalized object relations.

From a sociological viewpoint, this emphasis on internalized object relations as a crucial anchoring point for personality may be of particular interest. The basic unit of internalized object relations is the constellation of self- and object-image linked by a certain affect disposition reflecting instinctual needs, and reflecting, in essence, the early relationship between the infant and mother. The mother, in her interactions with the infant, not only responds with instinctive behavior patterns of her own and with her total potential of internalized object relations, but also with socially determined patterns of dealing with her baby. In other words, the mother enacts socially sanctioned roles in her interactions with the baby, and induces in the baby responses that gradually also become influenced by what the mother's expectations are of the baby's behavior at any stage of development.³⁹ The infant, in turn, in internalizing his relationship with the mother, also internalizes her roles as part of her object-image and his reciprocal roles to her as part of his self-image. According to some psychoanalysts, the term *introjection* should be reserved for the earliest internalization of object relations before awareness of and capacity for internalization of roles, while the term *identification* should be reserved for internalization of object relations at the point when the reciprocal role aspects of mother and child interaction are internalized as part of the self- and object-images.^{11,24}

In this way, the social system (represented by socially determined "status-role bundles") becomes integrated into the personality system from infancy on, and the mother-child interaction is considered, in effect, as a basic element of both the personality system and the social system.³⁸ As the self-concept develops, role integration and differentiation of the self occurs automatically with it; and as the child develops differentiated relationships with both parents and his siblings, these role differentiations acquire a highly sophisticated organization embedding the developing personality in the social system within which it develops. In addition, as the child grows up and assumes mothering, fathering, and sibling roles in relationship to other people, he "identifies" his self-concept with the internalized object representations that constitute his role model under such circumstances. Even before such later development, however, there exists, as part of the child's effort to retain the intimate relationship with mother by "becoming like her," such an activation of reciprocal roles. In replacement of the pathological refusal of self- and object-image characteristic of pathology at level 2, the child imitates mother in his fantasy and play as a means of closeness with her without losing his differentiation from her. This imitation is, to a large extent, an activation of internalized social roles. In short, the integration of socially sanctioned roles is backed up by a high, motivational investment linked with the development of internalized object relations.

In more general terms, internalized object relations may be considered as the crossroad where instinct and the social system meet and contribute crucially to the development of the personality of the individual.

REFERENCES

1. AINSWORTH, M. D., R. G. ANDRY, R. G. HARLOW, S. LEBOVICI, M. MEAD, D. G. PRUGH & B. WOOTTON. 1966. Deprivation of Maternal Care. Schocken Books. New York, N.Y.
2. AINSWORTH, M. D. 1967. Patterns of infantile attachment to mother. In *Behavior in Infancy and Early Childhood*. Y. Brackbill & G. G. Thompson, Eds.: 607-615. The Free Press. New York, N.Y.
3. ALANEN, Y. O. 1968. From the mothers of schizophrenic patients to interactional family dynamics. In *The Transmission of Schizophrenia*. D. Rosenthal & S. S. Kety, Eds.: 201-212. Pergamon Press Ltd. London.

4. BION, W. R. 1967. *Second Thoughts: Selected Papers on Psychoanalysis*. Heinemann. London, England.
5. BOWLBY, J. 1958. The nature of the child's tie to his mother. *Int. J. Psychoanal.* **39**: 350-373.
6. BOWLBY, J. 1966. *Maternal Care and Mental Health*. Schocken Books. New York, N.Y.
7. BOWLBY, J. 1969. *Attachment and Loss*. Vol. I. Attachment. Basic Books, Inc. New York, N.Y.
8. BOYER, B. & P. L. GIOVACCHINI. 1967. Psychoanalytic Treatment of Characterological and Schizophrenic Disorders.: 208-335. Science House, New York, N.Y.
9. DECARIE, T. G. 1965. Intelligence and Affectivity in Early Childhood. International Universities Press, Inc. New York, N.Y.
10. ERIKSON, E. H. 1953. Growth and crises of the healthy personality. *In* *Personality in Nature, Society and Culture*, 2nd edit. C. Kluckhohn & H. Murray, Eds.: 185-225. Alfred A. Knopf, Inc. New York, N.Y.
11. ERIKSON, E. H. 1956. The problem of ego identity. *J. Amer. Psychoanal. Ass.* **4**: 56-121.
12. FAIRBAIRN, W. D. 1952. Psychoanalytic Studies of the Personality. Tavistock. London, England. Also published as *An Object Relations Theory of Personality*. 1954. Basic Books. New York, N.Y.
13. FLAVELL, J. H. 1963. *The Developmental Psychology of Jean Piaget*. D. Van Nostrand Co., Inc. New York, N.Y.
14. FRAIBERG, S. 1969. Libidinal object constancy and mental representation. *In* *The Psychoanalytic Study of the Child*. Vol **24**: 9-47. International Universities Press, Inc. New York, N.Y.
15. FREEDMAN, D. A. 1970. On the limits of the effectiveness of psychoanalysis—early ego and somatic disturbances. Panel presentation at the American Psychoanalytic Ass. December. New York N.Y.
16. FREEDMAN, D. G., C. B. LORING & R. M. MARTIN. 1967. Emotional behavior and personality development. *In* *Behavior in Infancy and Early Childhood*. Y. Brackbill & G. G. Thompson, Eds.: 429-502. The Free Press. New York, N.Y.
17. FREEMAN, T., J. L. CAMERON & A. MCGHIE. 1966. *Studies on Psychosis; Descriptive, Psychoanalytic and Psychological Aspects*. International Universities Press. New York, N.Y.
18. FROSCH, J. 1964. The psychotic character: clinical psychiatric considerations. *Psychiat. Quart.* **38**: 81-96.
19. GELEERD, E. R. 1958. Borderline states in childhood and adolescence. *In* *The Psychoanalytic Study of the Child*. **13**: 279-295. International Universities Press. New York, N.Y.
20. GOLDFARB, W. 1967. Factors in the development of schizophrenic children: an approach to subclassification. *In* *The Origins of Schizophrenia*. J. Romano, Ed.: 70-91. Excerpta Medica Foundation. New York, N.Y.
21. HARTMANN, H. 1955. Notes on the theory of sublimation. *In* *Essays on Ego Psychology*, 1964: 215-240. International Universities Press. New York, N.Y.
22. HARTMANN, H. 1958. *Ego Psychology and the Problem of Adaptation*. International Universities Press. New York, N.Y.
23. JACOBSON, E. 1964. *The Self and the Object World*. International Universities Press. New York, N.Y.
24. KERNBERG, O. 1966. Structural derivatives of object relationships. *Int. J. Psychoanal.* **47**: 236-253.
25. KERNBERG, O. 1967. Borderline personality organization. *J. Amer. Psychoanal. Ass.* **15**: 641-685.
26. KERNBERG, O. 1970. Factors in the psychoanalytic treatment of narcissistic personalities. *J. Amer. Psychoanal. Ass.* **18**: 51-85.
27. KERNBERG, O. 1970. A psychoanalytic classification of character pathology. *J. Amer. Psychoanal. Ass.* **18**: 800-822.
28. KERNBERG, O. 1971. Diagnostic and therapeutic implications of ego weakness. Franz Alexander Memorial Lecture, Cedars-Sinai Division of Psychiatry. March. Los Angeles, Calif.
29. KERNBERG, O. 1971. New developments in psychoanalytic object relations theory. Presented at the Annual Meeting of the American Psychoanalytic Ass. May. Washington, D.C.

30. KLEIN, M. 1946. Notes on some schizoid mechanisms. *In* *Developments in Psychoanalysis*. M. Klein, P. Heimann, S. Isaacs & J. Riviere, Eds.: 292-320. Hogarth Press, 1952. London, England.
31. LIDZ, T. 1967. The family, personality development, and schizophrenia. *In* *The Origins of Schizophrenia*. J. Romano, Ed.: 131-138. Excerpta Medica Foundation. New York, N.Y.
32. MAHLER, M. S. 1968. On Human Symbiosis and the Vicissitudes of Individuation. Vol. I. *Infantile Psychosis*. International Universities Press. New York, N.Y.
33. MEDNICK, S. A. 1967. The children of schizophrenics: serious difficulties in current research methodologies which suggest the use of the "high-risk group" method. *In* *The Origins of Schizophrenia*. J. Romano, Ed.: 179-200. Excerpta Medica Foundation. New York, N.Y.
34. MEDNICK, S. A. & F. SCHULSINGER. 1968. Some premorbid characteristics related to breakdown in children with schizophrenic mothers. *In* *The Transmission of Schizophrenia*. D. Rosenthal & S. S. Kety, Eds.: 267-291. Pergamon Press Ltd. London, England.
35. MISHLER, E. G. & N. E. WAXLER. 1968. Family interaction and schizophrenia: alternative frameworks of interpretation. *In* *The Transmission of Schizophrenia*. D. Rosenthal & S. S. Kety, Eds.: 213-222. Pergamon Press Ltd. London, England.
36. MOYER, K. E. 1969. Internal impulses to aggression. *Trans. N.Y. Acad. Sci.* 31: 104-114.
37. OLDS, J. 1960. Differentiation of reward systems in the brain by self-stimulation technics. *In* *Electrical Studies on the Unanesthetized Brain*. Ramey & O'Doherty, Eds.: 17-51. Harper and Row, Inc. New York, N.Y.
38. PARSONS, T. 1964. The superego and the theory of social systems. *In* *Social Structure and Personality*: 17-33. The Free Press. London, England.
39. PARSONS, T. 1964. Social structure and the development of personality: Freud's contribution to the integration of psychology and sociology. *In* *Social Structure and Personality*: 78-111. The Free Press. London, England.
40. PAYNE, R. W. 1970. Thought disorder in schizophrenia and its implications for etiology and treatment. Presented at the conference on Schizophrenia—the Implications of Research Findings for Treatment and Teaching. June. Washington, D.C.
41. PIAGET, J. 1954. *The Construction of Reality in the Child*. Basic Books. New York, N.Y.
42. PRECHTL, H. F. R. 1963. The mother-child interaction in babies with minimal brain damage (a follow-up study). *In* *Determinants of Infant Behavior II*. B. M. Foss, Ed.: 53-66. Methuen & Co. Ltd. London, England.
43. ROSENFELD, H. A. 1965. Psychotic States: A Psychoanalytic Approach: 13-127; 155-168. International Universities Press. New York, N.Y.
44. SANDLER, J. & B. ROSENBLATT. 1962. The concept of the representational world. *In* *The Psychoanalytic Study of the Child*. 17: 128-145. International Universities Press. New York, N.Y.
45. SCHAFER, H. R. 1967. Objective observations of personality development in early infancy. *In* *Behavior in Infancy and Early Childhood*. Y. Brackbill & G. G. Thompson, Eds.: 626-739. The Free Press. New York, N.Y.
46. SCHULSINGER, F. 1971. Schizophrenia. Practical implications of genetics. Presented at conference on Schizophrenia—the Implications of Research Findings for Treatment and Teaching. June. Washington, D.C.
47. SEARLES, H. F. 1960. *The Nonhuman Environment*. International Universities Press. New York, N.Y.
48. SEARLES, H. F. 1963. Transference psychosis in the psychotherapy of chronic schizophrenia. *In* *Collected Papers on Schizophrenia and Related Subjects*: 654-716, 1965. International Universities Press. New York, N.Y.
49. SHAKOW, D. 1967. Some psychophysiological aspects of schizophrenia. *In* *The Origins of Schizophrenia*. J. Romano, Ed.: 54-69. Excerpta Medica Foundation. New York, N.Y.
50. SPITZ, R. 1945. Diacritic and coenesthetic organizations: the psychiatric significance of a functional division of the nervous system into a sensory and emotive part. *Psychoanal. Rev.* 32: 146-161.
51. SPITZ, R. 1965. *The First Year of Life*. International Universities Press. New York, N.Y.

52. VENABLES, P. H. 1967. Partial failure of cortical-subcortical integration as a factor underlying schizophrenic behavior. *In* *The Origins of Schizophrenia*. J. Romano, Ed.: 42-53. Excerpta Medica Foundation. New York, N.Y.
53. WINNICOTT, D. W. 1951. Transitional objects and transitional phenomena. *In* D. W. Winnicott: *Collected Papers*, 1958: 229-242. Basic Books. New York, N.Y.

DISCUSSION

DR. DAVID BIDNEY (*University of Indiana, Bloomington, Ind.*): In your discussion, you used the term "ego boundary." Where is it?

DR. KERNBERG: The "ego boundaries" term refers classically to the separation between experience of the self and experience of the outside world. In my own terms, and this is how I modified the concept, it refers to the function of the personality by means of which the origin of intrapsychic experience can be differentiated according to whether it stems from the inside fantasy, memory, or from the outside, such as perceptions, originating from the external world. This function, this capacity to separate the origin of intrapsychic experience is, of course, crucial to reality-testing, the capacity in which one is able not to have hallucinations, illusions, or delusions. So the most important clinical utilization of the term "ego boundary" refers to differentiation between self and nonself, and to reality testing.